

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014948	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/31/2013
NAME OF PROVIDER OR SUPPLIER ILLINOIS VETERANS HOME AT MANTENO		STREET ADDRESS, CITY, STATE, ZIP CODE ONE VETERAN'S DRIVE MANTENO, IL 60950		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	COMMENTS Investigation of Incident Report Investigation of 7/17/2013/IL64584	Z 000		
Z9999	FINDINGS LICENSURE VIOLATIONS Section 340-1440 Abuse and Neglect b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. Section 340.1500 Medical Care Policies 4)c) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident ... The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 340.1505 Medical, Nursing & Restorative Services b) General Nursing Care shall include at a minimum the following shall be practice on a 24 hour seven-day-a-week basis: 3) Objective observations of changes in a resident's conditions, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. e) All necessary precautions shall be taken to	Z9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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Z9999	<p>Continued From page 1</p> <p>assure that the resident's environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>This Requirement was not met as evidence by: Based on observation, interviews and record reviews, the facility's nursing staff failed to initially do an investigation into one resident's bruise of unknown origin and consistently monitor the residents for possible signs of injury, as well as provide specific staff interventions/supervision to prevent possible accident/incident. This resulted in the resident having bruising and fractured ribs, without staff being aware or knowing the cause of his injuries. This also prevented the staff from responding in a timely manner to assess and treat the resident's injury. This applies to one of three sampled residents (R2), who reside on a lock unit, and reviewed for close monitoring and observations.</p> <p>Findings include: Review of the facility's Abuse Investigation, dated 7/17/2013, documented the following: " ...R2 was sent to local outpatient clinic for a routine chest x-ray. ...outpatient clinic ...reported that R2 had sustained a mildly displaced fracture of the right second rib as well as ...lateral right fourth and fifth rib with a 30 % right hydro-pneumothorax and subcutaneous emphysema " R2 was immediately admitted to the hospital for medical treatment, including insertion of a chest tube to resolve his pneumothorax. The conclusion to this investigation was the facility's staff did not know the cause of R2's injuries.</p> <p>Review of R2's Stat (Face/Admission) Sheet</p>	Z9999		

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Z9999	<p>Continued From page 2</p> <p>documented he is a 79 year old male with diagnoses including: Alzheimer's disease, Dementia, Osteoarthritis, Glaucoma and Hypertension.</p> <p>Review of R2's care plan, started on 5/29/2013, documented R2 had a potential for " fall due to unsteady gait ... Confused, Wanders. The goal for this focus of R2's care was to: " ...Be Free of Injury Related to falls ... " The staff intervention was to check on R2 every 30 minutes for seven days. However after this seven day directive, no other staff intervention/method was identified to monitor and supervise R2 to prevent him from possible falls and injury.</p> <p>R2's care plan also document he needed supervision because of: "Impaired Decision-Making Skills. " This care problem identified several behaviors R2 displayed because of his " Impaired Decision Making " , such as: " Wanders in/out of other's rooms ... exit-seeking behaviors; up and restless at night; frequent bathroom visits at night; urinates in inappropriate areas ... " But, R2's care plan did not identify specific staff interventions being put in place to supervise R2 because of poor cognitive status and inappropriate behaviors that put him at risk for possible injury.</p> <p>Review of R2's Bath and Skin Worksheet documented the VNCA's (Veteran's Nursing Certified Assistant) observed R2 had a large bruise under the right arm on 7/08/2013 and 7/14/2013.</p> <p>Review of R2's nursing notes documented the nurse observed R2 had "dark purple bruising " right rib area with complaint of pain on 7/08/2013 at 9:27 PM. The nursing note, dated 7/09/2013 at 11:58 AM, documented no pain or bruising observed in R2's rib area. There is no further documentation of observations, assessments, or monitoring of bruising or pain for R2 until</p>	Z9999		

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Z9999	Continued From page 3 7/14/2013 at 1:32 PM. This nursing note documented R2 had bruising to the right side of the body, including the chest area to his abdomen. However, R2's bruising was not identified as a significant change in condition, nor an investigation started until 7/15/2013. Review of the Significant Change Form, dated 7/15/2013, documented that R2 had a bruise, which indicated a serious change in his condition. E5 was the VNCA, who first observed R2's bruising under the right arm on 7/08/2013. E5 was interviewed on 7/25/2013 at 4:21 PM, and stated: " I was assigned the member's (R2's) shower on (evening shift of) 7/08/2013. E5 said she saw a large oval shaped bruise under his (R2's) arm on the right side of his body. E5 said she told the nurse about R2's bruise. E3 was the nurse on duty the evening and night shift on 7/08/2013, who received the initial report of R2's bruising. E3 was interviewed on 7/26/2013 at 10:35 AM. E3 said R2 is a confused resident who needs direction to complete activities of daily living (such as: directions to bath, dress, and go to the bathroom.). But, E3 said that R2 could dress and feed himself. E3 stated that he observed a large oval shape bruise under R2's right arm on evening shift of 7/08/2013. E3 said he put a note in the computer that R2 had the bruise, and needed to see the doctor. But, E3 said he did not see R2's bruising as an immediate health problem. E3 indicated a Significant Change In Condition Form should had been completed. But E3 stated he never in the past thought about bruising as a possible injury, and bruising was recently added to the Significant Change in Condition Form. E3 said he let the day shift nurse inform R2's doctor. E3 stated he learned R2's bruising got worse in a few days. E3 said R2 was shy and no one observed him without his shirt off.	Z9999		

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Z9999	Continued From page 4 E3 stated no one notice the bruising spreading until his next shower on 7/14/2013. E4 is the VNCA, who observed R2 had bruising under the right arm, during his shower on 7/14/2013. Per interview with E4 on 7/26/2013 at 10:40 AM, E4 said she reported R2's bruising to the nurse on duty. E4 reported she was unaware that R2 had the bruising and was shocked to see the large area of bruising under his (R2's) arm. E4 said R2 needed coaching and reminders to do ADL's. E4 also stated R2 also needs supervision because he wanders around the unit and other resident's rooms. E4 said she redirected R2 out of other resident's room, but no other interventions were identified to supervise and monitor R2. E6 was another VNCA on duty on 7/14/2013 and observed the bruising under R2's right arm. E6 said she saw E4 put on the bathroom call light and went to see what happened. E6 reported seeing a deep purple bruise, which went from R2's arm pit to his waist. E6 said this was the first time she saw R2's bruising and no one reported he had any bruising. E6 also reported R2 needed staff supervision because he wanders into other resident's room and will try to get off the unit. E6 says R2 is provided with redirection and staff checks on R2 every 2 hours. However, R2 being on 2 hour checks were not sufficient intervention to effectively monitor/supervise R2, and ensure he (R2) remained safe from possible injury. E9 (the units manager) was interviewed on 7/25/2013 at 12:15 PM. Because R2 was observed to be an elopement risk, E9 said that R2 was transferred to the lock unit for close monitoring and supervision on 5/30/2013. E9 said that R2 was being checked on every 2 hours. E9 also indicated that R2 received a shower every three days. E9 indicated that	Z9999		

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Z9999	<p>Continued From page 5</p> <p>showers gave staff a way to assess R2 ' s body/skin for problems, since he dressed himself. E9 stated that R2 was scheduled to get a shower on 7/11/2013, but R2 refused his shower. So no one did an assessment of his skin or body check until 7/14/2013.</p> <p>R2's primary physician (Z1) was interviewed on 7/30/2013 at 12:20 PM. Z1 said that he examined R2 on 7/08/2013, but he did not see the bruising under R2's right arm. Z1 stated that the nurse left a message, the morning of 7/09/2013, that the bruise was on R2's chest. Z1 said the next time he observed R2 on 7/15/2013; he (Z1) observed extensive bruising on R2's right side. Z1 said he ordered a chest x ray because of the bruising, and the x ray showed R2 had rib fractures. Z1 stated he did not know for sure what caused R2's injuries. Z1 said that R2 ' s injuries could have been from a fall, a punch or he may have reached for something, lost his balance and fell.</p> <p>The director of nursing (E2) was interviewed on 7/25/2013 at 11 AM. E2 stated she was responsible for doing the investigation into R2's injuries. E2 said she was informed of R2's bruising on 7/15/2013. E2 stated a bruise is considered a significant change in a resident's condition. E2 stated when R2 developed a bruise on 7/08/2013, the nurses should have performed a more detail assessment of R2's condition and completed a Significant Change In Condition Form and Incident Report. Since this was not done for R2, R2 sustained an injury of unknown origin without staff providing accurate and timely assessment and treatment.</p> <p>(B)</p>	Z9999		

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